Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROBERT COOLBAUGH DC
2318 50TH STREET
LUBBOCK TX 79412

Carrier's Austin Representative Box
29

Respondent Name
LA MESA I S D

MFDR Date Received
July 20, 2009

MFDR Tracking Number
M4-09-A573-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "services were preauthorized which establishes medical necessity."

Amount in Dispute: $8,312.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has sent bills back to Bill Review."

Response Submitted by: Pappas & Suchma for La Mesa I S D, P. O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2009	Psychiatric Diagnostic Interview, CPT Code 90801 (1 unit)	$200.00	$200.00
February 9, 2009	Psychological Testing, CPT Code 96101 (3 units)	$390.00	$369.00
April 20, 2009	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours)	$937.50	$0.00
April 22, 2009	Chronic Pain Management Program CPT Code 97799-CP (7.25 hours)	$906.25	$0.00
April 23, 2009	Chronic Pain Management Program CPT Code 97799-CP (7 hours)	$875.00	$0.00
April 24, 2009	Chronic Pain Management Program CPT Code 97799-CP (5.5 hours)	$687.50	$0.00
April 27, 2009	Chronic Pain Management Program CPT Code 97799-CP (6.75 hours)	$843.75	$0.00
April 28, 2009	Chronic Pain Management Program CPT Code 97799-CP (6.5 hours)	$812.50	$0.00
April 29, 2009	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours)	$937.50	$0.00

April 30, 2009	Chronic Pain Management Program CPT Code 97799-CP (7 hours)	$875.00	$0.00
May 4, 2009	Chronic Pain Management Program CPT Code 97799-CP-CA (7 hours)	$875.00	$0.00
May 5, 2009	Chronic Pain Management Program CPT Code 97799-CP-CA (4.5 hours)	$562.50	$0.00
TOTAL		$8,312.50	$569.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 31, 2009
   - W9 –Unnecessary medical treatment based on peer review.

   Explanation of benefits dated May 14, 2009
   - 50 – not deemed a 'medical necessity' by the payer

   Explanation of benefits dated May 19, 2009
   - 50 – not deemed a 'medical necessity' by the payer

   Explanation of benefits dated June 1, 2009
   - 51 – this is a pre-existing condition
   - ANSI198 – Precertification/authorization exceeded.

   Explanation of benefits dated July 13, 2009
   - ANSI193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - ANSI216 – Based on the findings of a review organization
   - W9 – Unnecessary medical treatment – peer review
   - W9 – W9 – UNNECESSARY MEDICAL TREATMENT BASED ON PEER REVIEW.
   - W9 –Unnecessary medical treatment based on peer review.

   Explanation of benefits dated August 12, 2009
   - ANSIW1 – Workers Compensation State Fee Schedule Adjustment.
   - 222 – Charge exceeds Fee Schedule allowance
   - ANSIW3 –Additional payment made on appeal/reconsideration.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.240?
2. Is the respondent's denial reasons "W9" and "50" supported?
3. Is the respondent's denial reason "51" supported?
4. Did the requestor obtain preauthorization approval prior to providing the CPT Code 90801 and CPT Code 96101 in dispute in accordance with 28 Texas Administrative Code §134.600?
5. Did the requestor obtain preauthorization approval prior to providing CPT Code 97799-CP in dispute in accordance with 28 Texas Administrative Code §134.600?

6. Is the requestor entitled to reimbursement for CPT Codes 90801 and 96101?
7. Is the requestor entitled to additional reimbursement for CPT Code 97799-CP?

Findings

1. 28 Texas Administrative Code, Section §133.240(b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of the title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated February 4, 2009 supports the provider obtained preauthorization for the disputed services of February 9, 2009 for CPT Code 90801 x 1 unit and CPT Code 96101 x 3 Units under preauthorization number 05321 with a start date of February 4, 2009 and an end date of March 6, 2009, prior to providing the health care. Review of the submitted preauthorization letter dated March 30, 2009 supports the provider obtained preauthorization for the disputed services of April 20, 2009 through April 30, 2009 (Chronic Pain Management Program X 80 hours with a start date of March 30, 2009 and an end date of April 30, 2009) prior to providing the health care. Therefore, the aforementioned services will be reviewed per the applicable Division rules and fee guidelines. The disputed dates of service May 4, 2009 and May 5, 2009 exceeded the respondent's preauthorized approved time frame, therefore, will not be considered in this review.
2. The respondent denied the disputed services based on denial reasons "W9 – Based on the findings of the review organization and 50 – not deemed a 'medical necessity' by the payer." Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "the carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated March 30, 2009 supports the provider obtained preauthorization for the disputed services of April 20, 2009 through April 30, 2009 (Chronic Pain Management Program X 80 hours with a start date of March 30, 2009 and an end date of April 30, 2009) prior to providing the health care.
3. The respondent denied the disputed services based on denial reason "51 – this is a pre-existing condition." Review of the submitted documentation, the Division concludes that the respondent did not maintain this denial reason upon reconsideration, therefore, the disputed services will be reviewed per the applicable Division rules and fee guidelines.
4. 28 Texas Administrative Code, Section §134.600(p)(7), requires preauthorization of "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program." Review of the submitted preauthorization letter dated February 4, 2009 supports the provider obtained preauthorization for the disputed services of February 9, 2009 for CPT Code 90801 x 1 unit and CPT Code 96101 x 3 Units under preauthorization number 05321 with a start date of February 4, 2009 and an end date of March 6, 2009, prior to providing the health care. Therefore, the disputed services will be reviewed per the applicable Division rules and fee guidelines.
5. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated March 30, 2009 supports the Chronic Pain Management Program x 80 hours was approved under authorization number 05321 with a start date of March 30, 2009 and an end date of April 30, 2009 which includes the disputed dates of service, April 20, 2009, April 22, 2009, April 23, 2009, April 24, 2009, April 27, 2009, April 28, 2009, April 29, 2009 and April 30, 2009. The disputed dates of service, May 4, 2009 and May 5, 2009 exceeded the respondent's preauthorized approved time frame, therefore, will not be considered in this review.
6. Per 28 Texas Administrative Code, Section §134.203(c)(1) the calculations for CPT code 90801 x 1 Unit is as follows:

   CPT Code 90801 for DOS February 9, 2009: The 2009 Division conversion factor to be applied is $53.68. $53.68 WC CF/36.0666 Medicare CF x $147.04 Participating amount = $218.85.

   The total MAR for CPT code 90801 billed on February 9, 2009 is $218.85. According to the *Table of Disputed Services*, the requestor is seeking $200.00. Therefore, this amount is recommended.

Per 28 Texas Administrative Code, Section §134.203(c)(1) the calculations for CPT code 96101 x 3 Units is as follows:

CPT Code 96101 for DOS February 9, 2009: The 2009 Division conversion factor to be applied is $53.68. $53.68 WC CF/36.0666 Medicare CF x $82.64 Participating amount = $123.00 x 3 Units = $369.00.

The total MAR for CPT code 96101 x 3 Units billed on February 9, 2009 is $369.00. Therefore, this amount is recommended.

7. Per 28 Texas Administrative Code, Section §134.204(h)(5)(B), a chronic pain management program shall be reimbursed $125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. Review of the submitted documentation finds that based on the factual determination that the provider did not bill the disputed services with the –CA modifier, therefore, the monetary value of the program will be 80% of the CARF accredited value.

   DOS April 20, 2009: $100.00 x 7.5 hours = $750.00; Reimbursed $937.50, additional due $0.00

   DOS April 22, 2009: $100.00 x 7.25 hours = $725.00; Reimbursed $906.25, additional due $0.00

   DOS April 23, 2009: $100.00 x 7 hours = $700.00; Reimbursed $875.00, additional due $0.00

   DOS April 24, 2009: $100.00 x 5.5 hours = $550.00; Reimbursed $687.50, additional due $0.00

   DOS April 27, 2009: $100.00 x 6.75 hours = $675.00; Reimbursed $675.00, additional due $0.00

   DOS April 28, 2009: $100.00 x 6.5 hours = $650.00; Reimbursed $650.00, additional due $0.00

   DOS April 29, 2009: $100.00 x 7.5 hours = $750.00; Reimbursed $750.00, additional due $0.00

   DOS April 30, 2009: $100.00 x 7 hours = $700.00; Reimbursed $700.00, additional due $0.00

   DOS May 4, 2009: $100.00 x 7 hours = $700.00; Reimbursed $700.00, additional due $0.00

   DOS May 5, 2009: $100.00 x 4.5 hours = $450.00; Reimbursed $562.50, additional due $0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $569.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $569.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 5, 2012

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.